Whose Community Benefit?: Exclusion and Neoliberal Mentalities in Central Ohio's Community Health Needs Assessment

Undergraduate Research Thesis

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by

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"The Sisters of Holy Cross began their journey in 1886, to care for the poor and underserved in our community. More than 127 years later, Mount Carmel remains true to our mission "to improve the health of our communities" and Community Benefit is one of the most important ways we fulfill our mission." (Mount Carmel, 2012)

Introduction

A composite of "community" and "benefit," the mission of Mount Carmel West's community benefit program, a federal requirement of nonprofit hospitals, is to provide for unmet needs among the poor and to advance the health of their community more generally (Mount Carmel West, 2013). The governing logics of Mount Carmel's community benefit program warrant problematization to uncover what the hospital administration means by 'community' as well as how and why it intends to improve its health. The way that Mount Carmel administers and justifies its community benefit suggests a clear hierarchy of power in which the hospital conceptualizes health needs as the 'poor' individual's inability to manage him- or herself in accordance with societal norms and objectives. Rather than planning community benefit through an equitable cooperation among the underserved community and the general public, Mount Carmel administrators conceived of and imposed programs onto the community in a top-down manner to fulfil organizational goals such as reducing financial strains on the healthcare system. In this way, community benefit represents a tool of biopolitical power over a population. Neoliberal mentalities guide community benefit programming for Mount Carmel. Administrators privilege economic over social policy and increasingly devolve responsibility for health to the individual level.

Nonprofit hospitals like Mount Carmel have a nebulous history in the United States, and the Internal Revenue Service (IRS) has crystalized their changing and ambiguous healthcare role through sporadic rule changes and regulations since the mid-twentieth century. The most recent

of these requirements, The Community Health Needs Assessment (CHNA) established by the Affordable Care Act (ACA), mandates that nonprofit hospitals formally document the health needs of their community and implement strategies that they will address these needs. The CHNA attempts to articulate public health with the traditional healthcare system. The potential consequences of the new requirement are vast because nonprofit hospitals represent 60% of the nearly 5,000 acute-care hospitals in the United States (Rubin, Singh, & Young, 2015). The nonprofit designation of these hospitals also is significant. Tax exemptions for nonprofit hospitals totaled $12.6 billion in 2002 alone. Beyond the material consequences, the CHNA requirement formalizes the process of designing and administering community benefit programs. The requirement may potentially influence the way hospitals operate, but more importantly, it offers a rare glimpse into the guiding mentalities involved in community benefit programming.

Intended as an accountability mechanism to ensure that hospitals provide an appropriate level of community benefit, the CHNA requirement broadly dictates that hospitals take steps to engage the community and develop strategies to accommodate their health needs (Rubin et al., 2015). The IRS conditions for satisfying the CHNA requirement remain vague, allowing hospitals substantial leeway in how they define, engage, and ultimately address community needs. This paper critically examines the overarching mentalities and decision-making logics behind Franklin County's CHNA and Mount Carmel's community benefit program. Although scholars have studied the policy implications of the CHNA requirement (see Rubin et al., 2015; Young, Chou, Alexander, Lee, & Raver, 2013; Shaw, Asomugha, Conway, & Rein, 2014), much of the literature is uncritical. Thus, we know little about how hospitals have used the CHNA to effectively engage the community and respond to its needs. In the case of the Franklin County CHNA, hospital documents suggest that actual community involvement and engagement has

been scant. This paper uses the case study of Mount Carmel to draw broader implications and raise questions regarding the future of community health and the role of nonprofit hospitals in caring for the poor. I argue that the CHNA represents a neoliberal articulation between public health and traditional healthcare. This articulation results in the exclusion of the poor population that Mount Carmel intends to address and tasks them with bettering their own health.

Case Study and Research Strategy

This research was born from the lack of site-specific examination of neoliberal processes in the healthcare sector, especially in the realm of nonprofit hospitals. For the first time in history, the IRS has required nonprofit hospitals to document clearly their community benefit programs and to define the apparent health needs of their service area. The Franklin County CHNA included all four Central Ohio hospital systems—OhioHealth, Mount Carmel Health System, Nationwide Children's Hospital, and The Ohio State University Wexner Medical Center—I chose to narrow my research on Mount Carmel West Hospital because it was the only hospital of the four to publicly release their implementation strategy follow-up to the CHNA.[1] In evaluating the 2013 Franklin County CHNA, I noticed a contradiction—the document suggested the hospital had little involvement with actual members of the community (Central Ohio Hospital Council, 2013).

I begin with an overview of the history of nonprofit hospitals interweave a discourse analysis of public health in the United States and the Mount Carmel CHNA within the literature review. The discourse analysis sets the context for a series of semi-structured interviews[2] with

[1] The IRS requires only the CHNA to be made public. The IRS does not require hospitals to publicly post their implementation strategy. Mount Carmel chose to disclose their implementation strategy, while the other hospitals decided internally not to release their strategies.
[2] My research received IRB approval, protocol #2015E0093

six people including public health experts and hospital administrators who worked on the Franklin County Health Map or are involved in community benefit programing. Specifically, I examined the discourse surrounding public health in Central Ohio, primarily through the CHNA produced by the Central Ohio Hospital Association. I also examined numerous programmatic documents from Columbus Public Health, Mount Carmel, the Ohio Department of Health, and the U.S. Department of Health and Human Services. I then used the interviews to glean insights into the mentalities that guide their decision-making and justifications in community health planning. I interviewed a diverse range of stakeholders from the public health and prevention side to the healthcare administrator side to understand the different perspectives involved in producing the Franklin County CHNA. The paper concludes with a discussion drawing implications and research questions from the Franklin County CHNA.

Background: nonprofit hospitals in the United States

Contextualizing nonprofit hospitals and the provision of community benefit

The history of nonprofit hospitals and their evolving role in providing health care in the United States bear major implications for the ways that they care for their community today. Over three centuries nonprofit hospitals have transitioned from spaces of discrete medical care for the poor to their current mandate as managers of population health. Charitable organizations have operated since Colonial America, primarily administering medical related care to those who were unable to afford a private doctor (McGregor, 2007). Early 19th century almshouses, which sheltered the poor, emerged as secondary response to poverty and illness (Starr, 1982). The early American charity hospitals developed complementarily to almshouses and public hospitals as an attempt to separate out some of the sick from the poor and dependent and to provide an

alternative to the "more respectable poor with curable illnesses" (Starr, 1982, p. 150). The general public viewed these hospitals as houses of death for the 'homeless paupers,' soldiers, and victims of epidemics. The general public generally opposed the building of the charitable hospitals in their vicinity, viewing them as "unhappy necessities" (Starr, 1982, p. 151). Throughout the 19th century, hospitals, both public and private, predominantly operated as charitable institutions (McGregor, 2007). These hospitals were generally the only source of medical care for the poor. Typically, the hospitals served exclusively poor patients and charged a price equal to or marginally above the incurred cost of care.

Per Foucault, the poor were objects of medicalization in the 18th century because they were an integral part of the urban labor force and because the spread of disease among them was perceived as dangerous to the wealthy (Foucault, 2000). Disease represented a political and economic problem for social collectivities (Foucault, 1980). During the 18th century, the health of populations became a central goal of political power. The imperative of health was the duty of each individual and the objective of everyone in a society. Population health became the political-economic objective of medicine to increase the utility of the entire population. The medico-administrative role emerged to improve population health, mainly through hygienic programs to prevent the spread of infectious disease. Star (1982) explains the growth of the hospital as an alternative mechanism familial medicine to encourage the recovery and resumption of normal obligations among citizens. The family members no longer had to tend to their kin's illness, and the hospital became a workplace for the production of health. The biopoliticization of population health has existed since the 18th century (Foucault, 1980). The object of the new public health, however, is *preventing* disease in the individual rather than eliminating existing infectious disease among populations.

As charitable organizations specializing in poor care, the hospitals of the 19th century were tax-exempt. They largely derived income from philanthropic donations as opposed to profiting from patient fees or government subsidization. Through the conclusion of the 19th century and into the 1920s, hospitals changed drastically in function (McGregor, 2007). Instead of relying on voluntary donations, nonprofit hospitals began to derive income from patient charges. The nonprofit hospital that solely existed to care for the poor gradually faded during this era, and federal tax laws, namely the 1913 federal income tax, began to affect the profit-structure of the hospitals. The new federal income tax exempted nonprofit charities and allowed deductions for charitable donations. During the early 20th century, the development of health insurance also significantly changed the healthcare system. Patients no longer paid fees directly for services. Instead, insurance handled payments for treatment. Private philanthropic investment into nonprofit hospitals subsequently decreased. These changes resulted in cost and access problems for healthcare services. Congress attempted to remedy these problems through funding programs such as the Hill-Burton program, which provided loans and grants in exchange for nonprofit hospitals providing a reasonable amount of uncompensated care to the poor. The federal government only funded the Hill-Burton program from 1946 to 1974 and then began encouraging nonprofit hospitals to provide 'charity care' through the Internal Revenue Code. By virtue of their charity status, non-profit hospitals received tax benefits unavailable to for-profit hospitals, such as federal income tax exemption, the ability to issue tax free bonds, and the receipt of tax-exempt charitable contributions.

IRS involvement in regulating nonprofit hospitals principally began with the 1956 revenue ruling that developed a 'charity care' requirement (Congressional Budget Office, 2006). The requirement stated that a hospital must be operated to the extent of its financial ability for

those not able to pay for the services rendered. With the introduction of Medicare and Medicaid, the federal government speculated that nonprofit hospitals would no longer need to provide free or discounted care to the poor. Therefore in 1969, the IRS redefined the criteria for nonprofit hospitals to receive tax exemption, defining the promotion of health of any broad class of persons as a community benefit. The revised standard, now known as the community benefit standard, is still in use today. The tax exemption standard defines the provision of 'charity care' as broadly fulfilling several of the exemption-related criterion, including: (1) operate a 24 hour emergency room; (2) provide 'charity care' to the extent of the hospital's financial ability; (3) accept payment from Medicare and Medicaid programs on a nondiscriminatory basis; (4) maintain a community-controlled board; (5) make medical staff privileges available to all qualified physicians in the area consistent with the size and capabilities of the institution. The standard does not require that hospitals satisfy each criterion in all circumstances (Rubin et al., 2015). The ambiguity in the IRS requirements for nonprofit hospitals, the standards of which remained significantly unchanged since 1969, prompted debates over the accountability of nonprofit hospitals' community benefit programs, leading to the CHNA requirement of the ACA.

Importantly, the IRS requirements no longer required the nonprofit hospital to provide care for patients without charge or at a discounted price. The community benefit standard only requires hospitals to promote broadly the health of the community to qualify for tax-exemption. In 1983, the IRS loosened requirements on the IRS even further (McGregor, 2007). The community benefit standard was revised to eliminate the requirement that a nonprofit healthcare organization operate an emergency open to all. Instead, healthcare organizations only had to demonstrate other significant factors indicating that it was operating for the public benefit. Along with this ruling, additional IRS guidance clarified that a nonprofit hospital is required to make its

services available to the entire community and provide additional community or public benefits that sufficiently indicate that the organization primarily operates for the good of the public.

The new IRS regulations require nonprofit healthcare organizations to conduct a CHNA to better understand and engage the community they serve (Young et al., 2013). The IRS requirements for the CHNA are imprecise, allowing hospitals substantial flexibility in actually reaching out the community. Generally, each hospital's community benefit plan must include (1) a definition of the community that the hospital serves; (2) a description of the community health needs and a system for prioritizing those needs; (3) a description of the existing healthcare facilities and resources in the community that can address the identified health needs; (4) a description of the report methodology; and (5) a description of the process sued and a list of the organizations and people consulted to conduct the assessment. To fulfill criteria (5), a hospital must only involve persons who represent the broad interests of the community, including persons with special expertise in public health; federal, state, or local health departments; or leaders, representative, or members of a medically underserved community.

These new IRS requirements do not establish a concrete minimum value of community benefit that a nonprofit hospital must provide to qualify for tax exemption. Instead, the IRS employs a "facts and circumstances" test to determine whether a hospital's community benefit expenditures are sufficient to support its 501(c)(3) charitable status (Somerville, 2012). The new provisions to the IRS code require hospitals to complete a CHNA every three years and to report clearly the costs associated with community benefit programs in the hospital's tax forms. Each hospital may vary in the ways they define community benefit so long as they meet the general IRS requirements. The Mount Carmel Health System defines community benefit as "a measurement of the total amount of money, time and resources that are dedicated to provide care

or promote health and healing in response to identified community needs" (Mount Carmel, 2012). Mount Carmel defines its 'charity care' as follows:

> Benefits to the Poor include the medical care, education and programs that are provided to poor and underserved populations. Poor and underserved are those at 200% of or lower than the federally-defined poverty level, beneficiaries of Medicaid, or those who are "medically in jeopardy" (for example, low income HIV/AIDS and cancer patients and efforts to reduce infant mortality in these populations). This is what is traditionally referred to as "charity care." In accordance with our mission and as a tax exempt organization, Mount Carmel cares for everyone, regardless of ability to pay. (17)

In total, Mount Carmel's community benefit is comprised of the cost of health services provided to patients who uninsured or underinsured (traditional care), the cost of treatment to Medicaid patients who are not fully covered by the government, the cost of community health services and building activities, and the cost of medical education. In 2013, Medicaid reimbursement made up 45% of Mount Carmel's community benefit dollars; traditional 'charity care' 31.8%; and community health services and building activities 8% (Mount Carmel, 2013). The majority of Mount Carmel's community benefit spending still goes to treating the sick through covering the unreimbursed cost of Medicaid and providing free care to the uninsured. Mount Carmel spends a relatively smaller amount on the community outreach programs that it details in its implementation strategies. The focus in terms of money spent is on the hospital's traditional healthcare provision. A small amount is spent on activities that directly reach out to the 'community.' Although the IRS does not mandate minimum dollar values for community benefit, Mount Carmel must carefully consider the balance between community outreach programming and traditional sick care expenses.

The changes to the IRS code following the ACA have solidified the discursive role of the hospital as a population manager rather than a discrete source of healthcare provision for the poor, but the code does little to obligate concrete reform on the ground. The historical

underpinnings of the shifting duty of the nonprofit hospital highlight how they define the community and its needs. As the IRS mandates only that nonprofit hospitals operate to the benefit of the public, federal regulations increasingly permit hospitals to shift health responsibilities onto the community and individual. Although Mount Carmel has no legal obligation to provide a certain amount of sick care to poor individuals, it has continued to direct funding primarily toward this end. Thus, when it comes to improving community health outside of healthcare provision, i.e. health promotion and education activities, Mount Carmel has few legal or financial obligations. The hospital must simply identify health needs and indicate what it is doing or plans to do toward that end. The lax regulatory environment in that regard may contribute to Mount Carmel's relatively small expense toward community outreach activities and its ability to devolve responsibility for health to the individual level.

The Affordable Care Act and hospitals as population managers

A recent *New York Times* article emphasized the changing role of hospitals from spaces of sick care to apparatuses that intervene to regulate population health beyond the hospital walls (Tavernise, 2015). Healthcare providers around the country are trying to better manage patients who over-utilize the healthcare services, namely the emergency department for avoidable reasons. Many of these patients who use the emergency department are afflicted by poverty, homelessness, mental illness, addictions, or past trauma. According to the article, these patients raise new questions for the healthcare system including: "what is its role in tackling problems of poverty? And will addressing those problems save money?" One county health official highlighted these questions in stating, "We had this forehead-smacking realization that poverty has all of these expensive consequences in health care" (cited in Tavernise, 2015). Health

systems in the United States are beginning to take notice of issues such as poverty that have significant health consequences. For example, some medical teams are helping patients get bus passes and securing food for diabetic patients. John Vu, a vice president at Kaiser Permanente, one of the largest insurers and care providers in the country stated "This is the holy grail in research right now" (Tavernise, 2015).

The increased focus on public health and prevention is an intended effect of the ACA, which explicitly emphasizes the role of prevention in the healthcare system through the establishment of new national priorities, the implementation of prevention initiatives, the reduction of barriers to preventative services, the provision of funding for substantial public health interventions and infrastructure, and the fostering of collaboration between public health and traditional health care (Shaw et al., 2014). Historically, public health and healthcare systems have maintained a clear divide in operation. The healthcare system generally provides individual care while the public health system concentrates on disease prevention and population health management. The ACA developed guidelines, regulations, and incentive systems that directed increased focus on prevention and population health, notably encouraging hospital systems to work with public health agencies and other community organizations to develop community-based interventions (Shaw et al., 2014).

Literature review and conceptual framework:

Voids in critical medical literature

Extant literature on healthcare reform tends to examine impacts on entire sectors such as hospital systems, the insurance industry, and provider networks, rarely flushing out the reconfiguration of specific medical care spaces. Hossler (2013) reviews the critical literature on

healthcare services, noting the absence of three important areas of study in medicine: (1) the interaction and activation of macro-economic processes within specific medical spaces and practices; (2) developments outside of a few particular spaces in England, Australasia, and Canada; and (3) healthcare spaces beyond hospitals, long-term care facilities, and home care. As a consequence, critical literature often frames healthcare reform as top-down changes in state or federal policies that impact the medical service sector. This descending approach leaves many questions unanswered regarding the complex objectives of heterogeneous healthcare assemblages and the processes that shape the delivery of various forms of healthcare. This paper fills all three voids that Hossler (2013) identifies in field of critical health by examining the ways in which a variety of healthcare stakeholders in one city understand the changing landscapes of health beyond the hospital vicinity. In addition, this paper directly addresses another notable void in the literature—the role of the nonprofit hospital in its task to improve community health and care for the underserved.

The politics of health in the 21st century

Petersen and Lupton (1996) provide a useful Foucauldian framework for understanding the intervention of public health experts in neoliberal society. To borrow from their concept of the new public health in the age of risk, the administrative complex of the state, public health agencies, hospitals, and other healthcare practitioners devolve responsibility to the entrepreneurial self that must be ever vigilant of risks to the healthy body. The governmentality of the new public health targets population health to promote living a healthy lifestyle. This represents a shift in the objective of the old public health of the 18th and 19th century that

primarily focused on controlling infectious disease and eliminating filth through sanitary measures.

The new public health intervenes into private life through surveillance and disciplinary techniques aimed at preventing disease before it arises. The healthcare administrative-complex responsibilizes individuals through various health mandates, requiring them to regulate their own bodies in accordance with societal norms and goals. For example, public health experts view chronic diseases as a failure to take precautions against identified risk behaviors, such as eating unhealthily or refusing to exercise. Therefore, individual risk management has become an expectation of citizens under neoliberal governance (Bell, Salmon, & McNaughton, 2012). The state retains much of the responsibility that it acquired in the 18th and 19th centuries to secure general conditions for good health, like regulating food and drugs, organizing sewage disposal and water regulation, and through health promotion programs such as water fluoridation (Rose, 2006). However, through the 20th century and beyond the state has devolved many obligations for public health to nongovernmental organizations and individuals. The new public health redefines the responsibilities of the "healthy citizen" so that they are held accountable for both their own health and for the wellbeing of society at large (Petersen & Lupton, 1996). Public health officials construct citizens who fail to take responsibility for living a "healthy lifestyle" as drains on the healthcare system. The discourse of the new public health asks citizens to conform to societal goals for the sake of themselves as well as society. Health experts govern the conduct of individuals at a distance through educational and awareness initiatives that inform individuals on how they should behave. Certain lifestyles are constructed as unhealthy or risky if they could potentially burden society.

The pervasiveness of risk discourse, in which individuals and health status are constructed as societal risks, includes moral judgments and blame of those who lack conformity to national health objectives (Petersen & Wilkinson, 2008). Risk profiles are socially, politically, and culturally constructed despite their portrayal as scientific fact. The selection of some "risks" or dangers and the exclusion of others is a political and social choice shaped by many processes. Public health experts often treat health strategies to improve as an exact science even if they are subject to debate (Petersen & Lupton, 1996). The pursuit of good health becomes the obligation and the right of the citizen. Good health is needed to be a productive citizen and avoid being an economic burden on society. The neoliberal mentality of health is prominent as nonprofit hospitals increasingly design strategies to assess and improve population health.

Using the framework of Petersen and Lupton's (1996) "new public health," I examined how governing bodies at the national, state, and local level have defined and addressed health objectives. The World Health Organization, Centers for Disease Control and Prevention, and the U.S. Department of Health and Human Services (HHS) surveil, track, and record population health to issue broad objectives. The HHS specifically launched the Healthy People 2020 objectives that provide influential health indicators and objectives that are broadly disseminated and relied upon across the country. The programmatic statements from Healthy People 2020 indicate that this national governance largely subscribes to the new public health mentality. Focusing on obesity, a major target for chronic disease prevention, Healthy People 2020 states:

> The Nutrition and Weight Status objectives for Healthy People 2020 reflect strong science supporting the health benefits of eating a healthful diet and maintaining a healthy body weight. The objectives also emphasize that efforts to change diet and weight should address individual behaviors, as well as the policies and environments that support these behaviors in settings such as schools, worksites, health care organizations, and communities." (U.S. Department of Health and Human Services, 2015)

The excerpt casts the individual as responsible for maintaining his or her own health status.

Ohio's state health goals largely follow national objectives. The Ohio Department of Health's (ODH) strategic priorities for 2014 include curbing tobacco use, decreasing infant mortality, reducing obesity, and expanding patient-centered medical homes across Ohio (Ohio Department of Health, 2014a). Strategies for reducing infant mortality include a safe sleep campaign to promote awareness of safe sleep environments for infants specifically in areas of high infant-mortality rates. Strategies for combating obesity include intervening to create active lifestyles and healthy eating habits among children and creating communities that promote healthy living. In the ODH's plan to prevent chronic disease, obesity, physical inactivity, and poor nutrition are considered major risk factors for poor health (Ohio Department of Health, 2014b). The reasoning for addressing these conditions is that "along with their associated risk factors (high blood pressure, obesity, tobacco use, physical inactivity, poor nutrition), treating chronic diseases cost Ohio more than $50 billion every year in both healthcare costs and lost productivity from work." The report continues, "Yet much of this burden is preventable, and even small changes in the health of Ohioans now can contribute to preventing more than 600,000 new cases of cancer heart disease and stroke in the future" (Ohio Department of Health, 2014b). The state discourse treats obesity as a problem of efficiency. The health department transforms a key public health issue into a neoliberal matter of cost-effectiveness. Thus, the state health department strategizes to intervene to the point of reducing cost to the healthcare system. The state appears to ignore many of the barriers involved in being the healthy citizen, such as the everyday stressors of poverty that make it difficult for individuals to exercise and eat healthy. Instead, ODH considers the issues individual behavioral problems.

The goals of the state of Ohio are especially important considering Ohio Governor John Kasich's budget proposal for fiscal years 2016-2017 that prioritizes connecting "hospital community benefit to population health priorities" (Ohio Office of Budget and Management, 2015). The Executive Budget establishes a Population Health Planning and Hospital Community Benefit Advisory Workgroup to specify exact requirements for a nonprofit hospital to retain tax exempt status. The Workgroup would recommend the extent to which community benefit should be used to address prioritized population health outcomes in direct alignment with the regional Community Health Improvement Plan (CHIP) conducted by local health departments. The Workgroup also would consider the potential benefit of establishing regional community health and wellness trusts to receive and distribute hospital community benefit funds, tobacco settlement funds, or other grant funds in alignment with the regional CHIP. The budget proposal clearly attempts to align hospital programs with societal objectives, including infant mortality as a major priority. The state rearticulates its goals, requiring nonprofit hospitals to fill voids left by the public sector. As the state tries to align its goals with those of local health departments and nonprofit hospitals, its neoliberal justification and strategies to improve health become especially salient. This leads to hospitals mirroring the predominant neoliberal public health discourse in designing its community benefit programs. In this way, neoliberal mentalities are reproduced throughout the healthcare sector.

Columbus Public Health's CHIP directly aligned with state and national objectives in reducing infant deaths and reducing chronic disease. Columbus Public Health addresses Infant mortality through promoting safe sleep practices and educating individuals about safe sleep environments (Columbus Public Health, 2012). Specific strategies include: developing and displaying four infant safe sleep billboards in Columbus/Franklin County neighborhoods with

high numbers of infant sleep-related deaths; conducting community presentations to educate healthcare providers, childcare providers, and persons responsible for infant care on the American Academy of Pediatrics' recommendations to reduce Sudden Infant Death Syndrome; and developing infant safe sleep public service announcements. Strategies for reducing obesity involve increasing the number of women breastfeeding and increasing physical activity for mothers and children, among other interventions to promote healthy living.

National, state, and local goals have sought to normalize population health trends through interventions to promote the self-management of health. The neoliberal rationalities surrounding public health discourse in the United States bear increasing significance as the ACA attempts to bridge the gap between public health and health care. Neoliberal discourses in public health have inevitably influenced health care in the United States as it transitions towards a prevention-oriented model. As the state of Ohio tries to align its objectives and strategies with the hospitals' community benefit programs, the ways in which it defines and addresses health priorities becomes especially salient. In working with public health experts in central Ohio to produce the Franklin County CHNA, the neoliberal public health mentality inevitably influences how hospitals themselves define and address community health needs.

Discourses of the Franklin County Health Map and Mount Carmel community benefit: The neoliberal articulation of public health and health care

This paper conceptualizes neoliberalism as a mentality of governance that privileges economic rationalities and entrepreneurialism of the self (Foucault, 2008) rather than the emergence of a specific set of policy packages (Harvey, 1989). Foucault defines neoliberalism as the extension of the economic into all social fabric, or the economization of everyday life. The neoliberal mentality devolves responsibility to the individual level, in which each person is

tasked with managing all aspects of his or her life. Poststructural approaches to neoliberalism conceptualize it as a mentality of governance rather than a phenomenon that has evolved in a certain period of time (see Miller & Rose, 1990; N. Rose, 1993; Mcguirk, 2012). Policies and institutions are nevertheless important in a Foucauldian lens (Foucault, 2008). They represent the crystallization of broad societal mentalities. Neoliberalism is characterized by the rearticulation of goals and the role of the state in apparatus occurring in various ways across time and space (Defilippis, Fisher, & Shragge, 2006) rather than a categorical weakening or deregulation of the state. The strategies of regulation that constitute neoliberal governance are assembled into complexes that connect political institutions with apparatuses that shape and manage individual conduct in accordance with norms and objectives that are often deemed non-political (Rose, 1996). Power structures devolve health and welfare responsibility to the individual level to maximize his or her quality of life through acts of *choice* (Rose, 1996). Therefore, the neoliberal mentality treats disadvantaged individuals as authors of their own misfortune. Accordingly, disadvantaged people are engaged in an array of programs designed to reconstruct them as active, ethical citizens under neoliberal governmentality.

The neoliberal mentality repositions a range of problems in the community outside of the political realm, rendering them "technical and actionable" (Spence, 2012, p. 140). Experts play a crucial role in developing and administering strategies to address issues in the community, often treating deep-seated inequalities as technical problems. Expertise depoliticizes problems, prescribing them a narrow, technical solution that ignores a range of important structural factors (Spence, 2012). Experts' decisions on addressing community health needs vitally impact resource allocation and healthcare provision to particularly poor and vulnerable populations. The conceptualization of community health and the mentalities that guide decision-making have the

potential to marginalize "at risk" populations, rendering structural inequalities as personal problems that can be fixed with behavioral changes in the individual. Neoliberal mentalities that guide healthcare and preventative medicine also risk simplifying the range of complications and stressors that 'at risk' populations face in their everyday lives. Using this conception of neoliberalism, I examine how the CHNA process has articulated public health discourse and hospital governance.

The Franklin County CHNA steering committee, comprised of central Ohio hospital administrators, city and county epidemiologists, Ohio State public health experts, and a few community organization leaders, came together to produce the first Franklin County Health Map in 2013 (Central Ohio Hospital Council, 2013). The methodology of the report reflects the committee's understanding of the needs of the community, but it precludes an explanation of how or why Franklin County is defined as the hospital's service area. The main task of the steering committee was to come up with a list of key health needs in the community. The committee came up with eight priority health areas through a multi-staged process. The committee first considered all health indicators listed in the report, comparing them to state, and sometimes federal data for those indicators. Next, the committee selected the health indicators that were found to be worse than comparative state and federal data for consideration in the second step and dropped all other indicators from further analysis. The committee then ranked these indicators on a set of nine criteria:

1. Cost effectiveness- are potential results worth the financial investment?
2. Difference to similar jurisdictions- is the issue worse here than elsewhere?
3. External directives- are there federal/state mandates or laws or local ordinances that prohibit or require addressing the issue?
4. Feasibility of positively impacting- is there a valid intervention to positively impact the issue?
5. Magnitude of the problem- is a sizeable percent of population affected by the issue?

6. Mission critical/prevention potential- does intervention keep people well?
7. Quality of life- to what degree does the issue impede the ability for individuals to work, attend school, function?
8. Seriousness of consequences- does the issue cause severe illness and/or premature death?
9. Trend direction- has the problem worsened or improved in the last 5 years? (Central Ohio Hospital Council, 2013)

The steering committee clustered the needs into broader health issues and ranked them on a scale of 1 to 8.

Neoliberal mentalities saturate the mechanism to determine and prioritize the health needs of Franklin County. Community benefit was viewed as an investment that must yield some form of return rather than a social program to ameliorate vast inequities in health. The methodology leaves unclear what sort of result may be "worth the financial investment." Under this criterion, hospitals will prioritize a health need that can be addressed relatively cheaply over a need that may be prevalent but potentially costly to remedy. Health needs are objectified and compared to state or national level data to determine if they are worthy of investment. Thus, regardless of a community's beliefs about its health priorities, certain indicators of ill health are ignored automatically if they appear normal against state or national statistics. Also, health needs are prioritized based on the extent that hospital administrators believe that they have the capacity, or feasible chance, to intervene directly to yield a result. Finally, the central Ohio hospitals prioritize issues that hinder the ability to work, function productively, or otherwise operate as neoliberal subjects. If a health issue immobilizes an unproductive group of people, the hospitals' prioritization criteria exclude their needs. In sum, the hospital's prioritization mechanism reinforces neoliberal mentalities by treating health needs of the community as potential avenues of investment. Individuals are deemed unworthy of investment if strategies to address their needs are considered cost-inefficient. Further, health issues that impact small and

unproductive populations are invisibilized through data that homogenizes a populous and heterogeneous county. To be targets of 'charity care' programs, unhealthy individuals must demonstrate that they are worth the investment, are held back from being productive neoliberal subjects, and require the sort of support that a hospital can readily provide.

These criteria likely discount those individuals who need care the most, starkly contradicting the original intention of the community health needs assessment and community benefit more broadly. Small, marginalized populations may not register health needs on a large enough scale to be considered under the prioritization criteria. By focusing on county-level data, the hospital homogenizes a population exceeding one million people (United States Census Bureau, 2015), likely excluding the health needs of minority populations who are normalized in a statistical analysis. When narrowing health needs into individual indicators, the health status of populations also is rendered technical. For example, the broad range of issues that may contribute to high infant mortality rates are ill-considered when it is isolated to a single indicator. The standardization of health factors lends an 'objective' credence to the practice. These health promotion and education activities are relatively cost-effective as well compared to addressing structural influences on infant mortality, such as poverty and racism. In this way, the 'return-on-investment' mentality is grounded because it improves constructed health outcomes through efficient practices.

Mount Carmel West's implementation strategy report accordingly privileges economic mentalities. The hospital states as an objective of the report that:

> "This information empowers organizations to determine community benefit programming that will better serve its community. It is believed, with the correct resources to meet the needs of the community, unnecessary hospitalizations can be prevented, public health can be improved and the cost of health care can decline" (Mount Carmel West, 2013).

The stated justification behind community benefit programs is inherently neoliberal. The hospital prioritizes reducing costly avoidable hospital visits and reducing the cost of health care as the object of its charity. Under the heading of "Enhance the Health of the Community" Mount Carmel West lists as goals: "Expand chronic disease management programs;" "Educate and inform community on healthy behaviors;" and "Advance medical/healthcare knowledge." Under the heading of of "Demonstrate Value of Community Benefit," the hospital lists "Give community voice in decisions regarding community benefit strategy and activities;" "Demonstrate a return on investment;" and "Relieve/reduce the burden of government/other community efforts." The guiding goals of the implementation strategy privilege a neoliberal mentality because community benefit *investments* must yield some sort of return to reduce burdens on the healthcare system through education and health promotion programs.

In its implementation strategy, Mount Carmel West made note of the fact that its "facility experiences a high utilization of the emergency department for non-emergency care. This may be because the population in the surrounding area does not use primary care or needs assistance in managing chronic diseases or conditions." Mount Carmel defines a key community issue as the costly and unnecessary utilization of emergency department resources. This issue emanates from the hospital administrator's perspective rather than materializing from the voiced concern of any individual in the community. Additionally, the excerpt constructs the population as responsible for its own misfortune. Individuals in the surrounding area *choose* not to use primary care, or they are incapable of managing their chronic conditions. The hospital constructs the issue of over-utilization of the emergency department as one of the individual's failure to responsibly use healthcare services. Moreover, the key issue that Mount Carmel identifies is that emergency care is unnecessarily costly. One strategy Mount Carmel has identified to address the problem of high

emergency department usage, is the Community Health Resource Center, which offers monthly classes and support groups to increase breastfeeding rates, cooking classes, and tai chi classes. The goal of the Center is to better prevent and manage chronic medical conditions, encourage healthy lifestyle habits and promote holistic wellness. Mount Carmel also offers areas of primary care in two churches, a mobile outreach clinic, and a partnership with a local health center, but the hospital's implementation strategy includes no plan to increase access to those services despite access to care being the number one priority. The document reveals the absence of any new strategies to address access to care.

The number two priority is chronic disease. The implementation strategy states "According to the Centers for Disease Control and Prevention medical care costs of people with chronic diseases account for more than 75% of total medical care costs in the U.S." (Mount Carmel West, 2013). The goal is to improve self-management of asthma and diabetes through increasing awareness and education on self-management, continuing pharmaceutical programs for underinsured/uninsured individuals, and participating in community collaboratives to address obesity. Expected outcomes include better chronic disease management and decreased avoidable hospital admissions as a result of unmanaged diabetes or heart failure. Mount Carmel targets chronic disease because it is costly and unnecessarily burdensome to the hospital. Strategies devolve health management to the individual level, asking people to take it upon themselves to regulate their health in accordance with neoliberal societal goals.

Although interviews revealed that Mount Carmel prioritized infant mortality as the main focus of outreach programs, it is the seventh-ranked priority in the hospital's implementation strategy. The listed objective is to increase community awareness of infant mortality, preterm birth rate and low birth weight babies. Strategies planned to accomplish this objective include

convening a process to identify three potential programs/methods to increase public awareness, continuing programs directed at infant vitality, and participating in community collaboratives focused on infant mortality. Existing Mount Carmel programs to address infant mortality include breastfeeding promotion, infant safe sleep education, and trainings on positive parenting and bonding ("Mount Carmel Health System Schedule H (990)," 2012). Discourses around breastfeeding reflect and reproduce a neoliberal ideology of motherhood in which mothers are held responsible for the outcome of a child's health. Breastfeeding promotion ignores the structural influences on health. According to Colen and Ramey (2014) a mother's decision to breastfeed a child rests on a variety of personal, familial, and social factors. Breastfeeding requires mothers to dramatically reduce their work-hours outside of the household, have flexible jobs, or rely on wages from partners to compensate for lost income. Breastfeeding is a sacrifice for all women, especially poor or minority women who lack access to steady, full-time employment, flexible jobs, or partners with high salaries. Colen and Ramey (2014) conclude that narrow approaches which focus solely on individual behavior without addressing the socio-political realities that women face and the tradeoffs that they must make after childbirth actually risk alienating and stigmatizing the very group they intended to help. Mount Carmel treats infant health as a technical issue that can be remedied through a practical solution within the hospital's door. Breastfeeding promotion depoliticizes the vast structural challenges that many mothers face, potentially stigmatizing them even further. It economizes the mother-child relationship and holds the mother responsible for creating a healthy physical environment for the child.

More generally, the discourse around public health in the United States biopoliticizes populations. The logics behind public health and CHNA discourse economize everyday life so that strategies intervene to normalize populations to conform to societal goals. Social policy

becomes economic policy as hospitals care for and reach out to the community in a privileged manner that seeks to identify what is wrong with individuals and correct them in accordance with state and national goals. Neoliberal mentalities devolve responsibility for health-management to the individual level in the community. Hospitals impose charity care onto individuals for predefined reasons rather than community health improvement resulting from a two-way discourse between administrators and the public.

Interview analysis: Understanding the complex neoliberal mentalities involved in the Franklin County Health Map and Mount Carmel's community benefit programs

Conceptualizing community: The Franklin County CHNA as an exclusionary mechanism

The discourse of 'community' carries positive connotations, and thus, the term routinely is considered unmistakably 'good' (Defilippis et al., 2006). Using the language of community empowerment and participation, new public health discourse is often used to achieve support for predefined objectives determined by 'experts' (Petersen & Lupton, 1996). As Rushton (2014) adds, health planners can objectify and instrumentalize communities to constitute sites of veridiction and intervention. Public health experts often narrowly define and impose the meaning of 'community,' giving priority to locality over the multitude of factors and lived experiences that contribute to an individual's identity. In defining community as a carved out region, public health experts proceed on the assumption that there is an objectively existing community that can readily be located and engaged in ways that will necessarily be empowering for participants. This location-based approach is problematic because it risks excluding individuals outside of a narrowly defined location and ignores processes occurring beyond the bounded space. Forms of community participation and empowerment can involve the outright exclusion of undesirable

people and the reification of narrowly defined conceptualizations of community (England, 2008). The nature of community participation, therefore, is not self-evident across time and space, calling for localized problematization (Huxley, 2013). The ways in which an organization defines and engages a community determines how it understands and responds to its needs. The various ways that community is defined and acted upon call for a localization of 'community' in the case of Mount Carmel's CHNA. As the neoliberal mentalities and conceptions of community in the Franklin County CHNA represent the crystallization of the thoughts and guiding principles of a multitude of actors, it is important to understand their individual thought processes and justifications.

The neoliberal mentality has influenced the Franklin County CHNA from the prioritization process to designing strategies that address the identified health needs. The document itself, however, precludes the ways in which those involved in producing the CHNA understood the community that they were tasked with engaging. Interviews revealed that the steering committee chose Franklin County as the community because it was the smallest area for which secondary data was available. One interviewee noted that 85% of the hospital's patients come from Franklin County, but the steering committee was content with having its analysis at this level (Columbus public health expert). The interviewee also recalled that hospitals had requested data at a finer level, but they were unable to secure more localized data. One public health expert noted that hospitals could dig through their own data, such as discharges, admissions, and insurance information to complement the Franklin County statistics. This approach would necessarily discount any person who was not on file with the hospital, or any person who had never accessed healthcare at a specific healthcare facility. Still, the interviewees expressed that county-level data are useful because they could be compared to state and federal

levels in most cases to determine health needs. The ultimate decision to use Franklin County as the community suggested that those involved on the steering committee were uninterested in localizing analysis at a finer level. This conceptualization of community suggests that hospital administrators addressed community engagement principally as a means to reinforce their preconceived notions. The CHNA process became a tool to reify the hospital's existing community benefit strategies.

When asked about limitations to using secondary data exclusively and relying on a small steering committee, one interviewee stated, "The steering committee was good last time, but I am not sure if the steering committee was representative of the community. Alright, so yeah we had both health departments on the committee, we had the United Way, we had the FQHCs, but are there other parts of the community that weren't there?" (Central Ohio hospital administrator). The administrator expressed interest at the idea of including more stakeholders such as a representative from the disabled community or the department of aging. The administrator, however, voiced concern over the steering committee potentially becoming too large to prevent anything from getting done. Another public health practitioner indicated that the steering committee could have been much larger, recalling previous steering committees that the person had been a part of involving 80-100 people. The expert stated, "I don't think the steering committee is that large. For a county that is the size of Franklin. It is pretty limited… There is no general community member represented. So the public voice in addition to the organization and stakeholder voice [is absent]" (Central Ohio public health practitioner). The same person also criticized how hospitals have historically engaged the community.

> "I think historically they see what presents to their door. Their admissions, their ER visits. I think that's historically what they see and maybe how they view that community. I think they have done a better job of getting out and about than they used to. Maybe that will continue to influence how they see the community as

> opposed to just what is in their walls and parking lot." (Central Ohio public health practitioner)

Although most of the interviewees were expressed satisfaction with using Franklin County as the service area for the CHNA, some expressed a lack of full community involvement. Importantly, interviewees did not define community involvement as a direct engagement with the public. Instead, community engagement meant having more organizational leaders who could represent various interests of the public. Thus, community was conceptualized politically as a top-down strategy. The hospital objectified the community to implement its strategies. The methods used to define and prioritize health needs invisibilized the everyday challenges that individual community members may face in accessing health care and managing their health conditions. The Franklin County Health Map therefore was an exclusionary tool that fell short in actually reaching out to the community to understand and engage with its complex health needs. The wide array of health and social needs of hospital communities remain unclear through this process. The Central Ohio hospitals localized health needs internally through admission and discharge data. Therefore, the way in which hospitals understood populations outside of its doors also remains unclear.

The steering committee as a messy assemblage

Although the Franklin County Health Map 2013 portrayed the steering committee as a tidy collaborative effort among a variety of stakeholders, consensus was rare among its members. The steering committee was a messy assemblage that represented a broad range of perspectives, differing ideas, and hierarchical power relations. As one public health practitioner put it: "Was there 100% agreement on everything? No. And honestly, I think that is why we ended up with eight very broad priorities." The interviewee continued,

> "[The hospitals] are focusing on one or two of these areas. They still had to address how and why they were not addressing these other areas. So it could be perceived that there is a little bit of something in each one of these for somebody in the room. So I got what I want. You got what you want because… we didn't really make hard choices about true priorities… We didn't want to lose this other thing because it is somebody's baby." (Central Ohio public health practitioner)

Other interviewees noted the challenges of having a large set of different individuals on the steering committee. As one hospital administrator commented,

> "You have probably 20 people on the steering committee representing maybe a dozen different organizations. They all have their own ideas. The health department is very involved in infectious disease, the public health type issues. SO they certainly have a slant. The hospitals are more involved in more inpatient, outpatient care. So it was herding cats a little bit." (Central Ohio Hospital Administrator)

Another Columbus public health expert expressed challenges in the different perspectives at the table, commenting, "if you talk to people throughout the state and in other states, it sounds like it is kind of rare to get public health and hospitals to the table to agree on anything… there is some negotiating and compromise" (Columbus public health expert). Another public health expert observed, "I think that we occupy different parts of the system… the hospital is still very much in a lot of ways… sick care… we tend to be more prevention oriented… I think that is kind of a new thinking process for the hospital system" (Columbus public health expert). Because the steering committee was a site of contestation, the Franklin County CHNA process was a tool for empowering hospitals and public health goals. Hospital administrators and public health experts fought to prioritize their own constructed notion of community need.

One public health practitioner brought to light the complex power relations that existed on the steering committee. The hospitals brought on the public health experts as community representatives *and* consultants on the project. The person conveyed concerns over the challenges of hospital executives contracting the public health practitioners as a client rather than

as an equal player determining community health needs. The interviewee stated, "Anytime you get big players in a room with people that are not big players, it is a hard line to walk" (Columbus public health practitioner). The interviewee continued on the aspect of being a consultant to the hospitals (the client) in saying:

> "We had an opportunity to influence how hospitals thought about things or approach things… And, being the hospital council was our client, so of course we are going to do what they want us to do. We can influence that, but we can't necessarily change it… I just think there are some limitations to the process in getting the two parties—being hospitals and public health—together." (Columbus public health practitioner)

The interviewee highlights the challenges of the hospitals controlling the CHNA process. The parties come to the table as unequal stakeholders. Hospitals led the CHNA procedure and used input from 'community representatives' to the extent that they decided fit because the 'community representatives' were consultants first and representatives second. The client-provider relationship between the hospital executives ("big players") and the public health personnel ('community representative') created clear hierarchies of power where the public health experts were expected to cater to the requests of the hospital administrators. Therefore, the 'community representative' was only a representative to the extent that the hospital wanted him or her to be. The notion of community was entirely one-sided, with the hospital dictating how the 'community representative' actually was able to represent the community. This unequal power relationship invisibilized any health need that the hospitals chose to exclude by clearly defining the role of the public health experts of providing the information that the hospitals wanted.

Nonprofit hospitals navigating new population management roles in an age of uncertainty

Both the public health experts and the hospital administrators recognized the vast changes occurring with the changing role of the nonprofit hospital and expressed the difficulties they have faced in adapting to that role. One central Ohio hospital administrator described,

> "I think that the hospital purview is changing. We used to be these brick buildings that had four walls, and you came there because you were really sick. And we got you better, and we sent you home… that was the end of our relationship. I think the role of the hospital is changing. You talk about social determinants, poverty and education, access to food. You know, a hospital can't solve those issues." (Central Ohio hospital administrator)

Hospital administrators also talked about how they are being incentivized by federal rules and regulations to play a more preventative role. The interviewee explained that reimbursement, incentives, and penalties are changing to keep people out of the hospital. With this changing role, hospital administrators expressed an unwillingness to make wholesale changes due to the vast uncertainties in healthcare in the United States.

> "We have a president that has a couple years left. We have a governor that maybe has four years left. We have a brand new republican congress that would still love to do away with the entire thing… It is really hard to fully invest in these programs when there is so much uncertainty… around are we heading in this direction or are we not." (Central Ohio hospital administrator)

Hospitals have demonstrated a reluctance to adapt to their new role in part because of the newness and drastic change brought about by the Affordable Care Act. Administrators have also clarified that they lack capacity to effectively bridge the gap between population health management and discrete sick care. Even after stating that the hospital purview is changing, hospital administrators deemed many socio-political influences on health to be beyond their expertise and capacity. As hospitals hesitantly straddle this role as a preventative health force, they are reluctant to engage in community benefit programming that is long-term and costly in nature. Why should they invest in costly long-term planning if the IRS rules and requirements may change in the future?

Accordingly, Mount Carmel administrators decided to focus on infant mortality as its main target of community outreach programs because they already had programs in. One Mount Carmel administrator explained that "since infant mortality was the big push with the mayor and also with public health and also because we were already working on that, it was one of the things that we decided to do." Hospital administrators conceived of community benefit as investments that must be narrowly targeted to yield the greatest outcome. One hospital administrator stated that community benefit is "not an endless bucket of money," and investments must be wisely targeted because hospitals "cannot do it all."

> "So I think when the hospitals do look at these things, they are going to say we have a limited amount of dollars so how can we spend those dollars? I don't want to say low hanging fruit because you certainly want to invest in things that are impactful… But is this a health need that affects a lot of people or a small few? Are the investments significantly making an impact, or can you spread a little bit of seed money to have an impact?" (Central Ohio hospital administrator)

For the hospitals, the CHNA was an opportunity to reinforce organizational capacity rather than envision new ways to address community health needs. A Mount Carmel community benefit administrator decided to focus only on those needs that they "had resources and capacity" to address. Focusing on ameliorating infant mortality, administrators acknowledged the role of housing, food access, jobs, and education on a person's livelihood and health. Yet, the hospital lacked new programs to address these needs because it was beyond their expertise. Mount Carmel administrators stated that they plan to partner with other organizations that have the capacity to address these issues, but they left unclear the specific role of the hospital. One Mount Carmel administrator referred to the hospital as "a resource to connect people" because they were incapable of doing "everything for everybody." The hospital administrators, paradoxically, saw their role as comprehensive population managers yet unable to actually be a singular source for population needs at the same time.

Struggling to be a comprehensive population manager and implement cost-effective strategies, Mount Carmel largely devolved responsibility to the individual. A large part of the hospital's outreach programs focus on educating people on how to be healthy and promoting a healthy lifestyle.

> "We do have our community resource center downtown on the west campus. And we have many, many different kinds of classes for people. You have tai chi classes for the elderly and cooking classes… And with the moms to be we're teaching them how to cook different things. Not the potato chips that they want and the beer that they want. It's the vegetables and the things like that." (Mount Carmel administrator)

As stated in Mount Carmel's programmatic documents, they do have a mobile clinic and two church-based clinics to provide urgent and primary care. In the interviews, the mobile clinic was constructed as a program that prevented people from making costly and unnecessary emergency room visits. One Mount Carmel administrator described the program as "a service for the community, but it also helps us." Mount Carmel also has a street medicine program where they sporadically visit areas of homelessness to provide some primary care and to connect them to the right resources such as help for mental health. The Mount Carmel administrators mentioned that they had one employee whose sole purpose is to address the nonmedical needs of vulnerable populations by connecting them to resources. Yet, Mount Carmel's CHNA lacked any plans to increase these programs which address the issue of access beyond responsibilizing the individual. The main rationale behind increasing access to care was to decrease costly emergency department utilization. Therefore, it is likely that these programs are only implemented to the extent that they do just that.

Meeting the requirements: The IRS and bureaucratic constraints

One central Ohio hospital administrator candidly expressed that the hospitals did a poor job with reforming their strategies to meet community health needs. This administrator, however, blamed the lack of material changes on time constraints imposed by the IRS.

> "With the hospitals it was a timing issue. We had the report, and the way the regulations were written with three, to four, to five months we had to have all of these strategies developed with how you are going to address these health needs. It just wasn't enough time. So I think with that first set of strategies the hospitals did, they pretty much identified programs that they already were doing to address a lot of these health needs." (Central Ohio hospital administrator)

The administrator expressed that hospitals were under a tough deadline to fulfil IRS requirements or else they faced a fine and potentially losing their nonprofit status. The administrator believes that having more time and experience with the next community health needs assessment will lead to more changes in strategies to better address community needs. Thus, this first CHNA process was primarily about satisfying IRS requirements rather than actually attempting to engage the community. Testimony from the Mount Carmel administrators, however, suggested that the hospital was constrained primarily financially. They also demonstrated an unwillingness to make wholesale changes to their community benefit program because of uncertainty in the IRS requirements and the future of the ACA more broadly. They even hoped to continue their focus on infant mortality years into the future. It remains unclear whether the hospital will in fact change its strategy to better meet the perceived needs of the community or if it will continue to build its capacity to address issues within its purview. Acknowledging time and bureaucratic constraints, it is still a concern that hospitals will continue to do just enough to satisfy the IRS because of a lack of incentives to encourage anything beyond the minimum requirements. One hospital administrator commented that the hospitals will do a better job implementing strategies for the next needs assessment with more time and experience (Central Ohio hospital administrator). Most of the interviewees additionally believed that the

steering committee could at least have been more representative. The general attitude toward making improvements with the next CHNA suggests it is possible that hospitals will make more meaningful changes. Future research will have to examine if hospitals will improve after multiple CHNAs to actually engage the community and implement meaningful strategies to address community needs.

Conclusion and Implications for future research

This paper brings to light the neoliberal mentalities that saturate decision-making in nonprofit hospital community benefit programs. Hospitals such as Mount Carmel skirt their 'charity care' mandate by excluding the community from decision-making and implementing programs based on cost-effective rationalities rather than social concerns. The hospitals effectively treat the poor as objects to normalize population health in accordance with societal objectives. 'Charity care' is constructed as a way to intervene on populations and reproduce neoliberal citizenship, tasking individuals with disease self-management. The intertwined nature of 'charity' and 'community' suggest that the targets of community benefit programs are not so humanitarian but focused on organizational goals such as reducing financial burdens. The poor often have less voluntary contact with medical professionals than those who are financially secure (Starr, 1982). As such, they are more dependent on hospitals and more likely to be enrolled in societal projects aimed at creating 'healthy citizens.' Thus, this research calls for future study of how other hospitals in the nation have defined community and sought to care for their needs as they exert biopower over the 'community.' Future research will have to engage members of the community to fully understand their health needs and the effects of their exclusion from community health planning. Research should also engage a wider set of people

(e.g. medical practitioners such as doctors, nurses, aides) involved in administering community benefit programs to understand the exact ways they understand and care for underserved populations. It is important to note that preventative health is not necessarily neoliberal in all cases. Although this paper does not address resistance to neoliberal mentalities, it sheds light on the ways in which alternative approaches might be conceived. Future research may explore how the community and poor populations are engaged in ways that do not objectify them and subject them to programs to fulfil societal goals.

This paper leaves many questions unanswered such as: what are the actual health needs of the community? Are all hospitals cherry-picking priority issues based on existing priorities? What are the consequences of that narrow approach? Have other hospitals directly engaged the community? Can health reform effectively change the role of the non-profit hospital regarding community engagement? Vast uncertainties in health care led Mount Carmel to retrench in its community benefit programs. These uncertainties in a time of vast healthcare reform, however, open new, unimagined possibilities to care for the poor. The community health needs assessment mandate could open the door for nonprofit hospitals to better understand communities and address their needs in ways that resist neoliberal rationalities. This research highlights the need to study these institutions and the ways that their community health planning may change in the future.

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